

8.1 Recommendations

Recommendations from the Lead Review Team Report

The Lead Review Team considers that the following action needs to be taken:

1. Develop and resource a fifth National HIV/AIDS Strategy that will:
 - ◆ include a major prevention education program focusing on men who have sex with men—as the continuing highest-risk group—targeting high-risk environments (such as sex-on-premises venues) and hard-to-reach groups (for example, men who have sex with men but do not identify with the gay community) and being guided by epidemiological and social research data
 - ◆ be a component of a national prevention and education program promoting safe sex to the general community—that is, a program aimed at preventing STIs
 - ◆ have a greater focus on the complex and diverse needs of people living with HIV—including their mental and social health
 - ◆ following a review of the testing guidelines, promote regular HIV testing among at-risk groups, with the aim of reducing the number of people with undiagnosed HIV
 - ◆ provide support for targeted approaches such as peer education for hard-to-reach vulnerable populations—for example, sex workers and injecting drug users
 - ◆ take account of the specific needs of groups from culturally and linguistically diverse backgrounds
 - ◆ incorporate an integrated evaluation framework
 - ◆ incorporate the principles and targets of obligations arising from UNGASS—the UN General Assembly Special Session on HIV/AIDS.

The Lead Review Team recommends that planning for a fifth national strategy begin on acceptance of this report, with the aim of the strategy coming into operation by mid-2003.

6. Undertake an assessment of the growing care needs (including the mental health care needs) of people living with HIV/AIDS, to identify current barriers to effective and efficient care and the health sector's capacity to respond to likely future demand.
7. Support a re-evaluation by the key community partner organisations—gay, injecting drug user, and sex worker organisations—of their constituencies, roles and priorities, particularly in relation to prevention of HIV and STIs and the care of people living with HIV/AIDS, with the intention of re-invigorating constituency involvement in programs of support and prevention.
8. Development of a whole-of-government policy on Australia's role and responsibilities in relation to the international HIV epidemic
9. Review and implement other recommendations of the HIV Strategy Review Team, consistent with the recommendations of the Lead Review Team.
6. Clearer identification and championing of hepatitis C as an urgent national public health problem by the medical and public health community.

7. Develop and resource an improved second National Hepatitis C Strategy, drawing on the findings of this first review, to be in effect by mid-2003.
10. In recognition of the potential future health care costs posed by hepatitis C, commensurately increase investment in efforts to prevent the spread of the virus.
11. Implement a program to improve and expand current harm-reduction strategies, including:
 - ◆ implementing best-practice models for NSPs—involving training of NSP workers, better referral systems, and proactive local management systems to allay community concerns
 - ◆ increasing the availability of medical detoxification—with particular attention to accessibility outside metropolitan areas
 - ◆ improving access to substitution therapies such as methadone and buprenorphine
 - ◆ investigation of other approaches to reducing injecting as the preferred method of drug delivery.
10. Develop and implement specific programs for preventing the spread of and for treating blood-borne viruses in prisons. This needs to include more effective harm reduction in prisons and improved coordination of prevention and care services between prison and the community, as is currently being strived for in drug-dependency services.
11. Uniformly regulate the body-piercing and tattooing industries—to ensure that these industries do not become a growing source of infection while not being so prohibitive that young people are forced into unsafe practices.
12. Resource a specific research program dealing with the issues that will inform policy and practice—including the epidemiological, social and cultural aspects of risks and transmission and the barriers to seeking treatment.
13. Develop and implement improved surveillance methods for hepatitis C.
14. Implement a process to review the national implications of the findings of the New South Wales Anti-Discrimination Board's 2001 enquiry into hepatitis C-related discrimination.
15. Ensure greater involvement of at-risk groups in strategy planning and implementation—with particular attention to the use of peer-group education.
16. Ensure greater engagement on the part of the Intergovernmental Committee on Drugs and drug-dependency services in matters associated with the physical health of injecting drug users—including greater commitment to controlling the spread of hepatitis C.
17. Review and implement other specific recommendations of the Hepatitis C Strategy Review Team, consistent with the recommendations of the Lead Review Team.
18. Review the contracts between the Commonwealth Department of Health and Ageing and the National Centres in HIV Research, to specify as clearly as possible the elements of funding for surveillance and monitoring and for strategic research.
24. For the Population Health Division, convene, at least yearly, round tables of stakeholders, to identify and set priorities for strategic research.

25. Within two years, carry out an assessment of the National Centre in HIV Social Research and the Australian Research Centre in Sex, Health and Society to ensure that the concerns about the reach of their research programs are addressed.
26. Begin negotiations to identify funding for and a process for establishing a research program for hepatitis C.
27. Monitor the funding transition process to ensure that relevant strategic research is not interrupted.
28. Review and implement all specific recommendations of the Strategic Research Review Panel, consistent with the recommendations of the Lead Review Team.
29. It is thus recommended that, as the principal point of governance, each strategy have a governing committee appointed by the Minister for Health and Ageing. Membership of each committee should represent all members of the partnership, but must include the following:
 - ◆ relevant specialist medical expertise
 - ◆ general practice
 - ◆ the non-government partners
 - ◆ the Indigenous community
 - ◆ public health expertise
 - ◆ health promotion, research and evaluation expertise.
30. The Team considers that a joint coordinating committee would be appropriate, with responsibility for legal matters and harm reduction. If this model is accepted, such a committee's terms of reference should make it clear that it does not have executive decision-making powers in relation to the individual budgets for HIV–STIs or hepatitis C. Its membership should include the chairs of the HIV–STIs, Hepatitis C and IGCAHRD Committees and representation from the Australian National Council on Drugs (ANCD).
31. The Lead Review Team considers that the specific concerns of Aboriginal and Torres Strait Islander peoples warrant the continuation of a separate committee for the Indigenous Australians' Sexual Health Strategy. Moreover, since this strategy has set out to achieve a holistic approach to STIs, HIV and hepatitis C—in keeping with the philosophy of broader Indigenous health—it is appropriate that the chair of the committee be a member of the coordinating committee.
32. In the Team's view, the Legal Working Party should continue to provide support to both strategies and therefore is most appropriately represented through the coordinating committee
33. The size and impact of the global HIV epidemic are such that the Lead Review Team considers there is a need for a whole-of-government international policy on Australia's role in tackling the problem. Such a policy would specify the following:
 - ◆ how Australia's reporting obligations under the UNGASS agreement will be met and who will coordinate the process
 - ◆ funding priorities for aid

- ◆ development and maintenance of a human resource base to support international efforts
- ◆ development of a system to ensure better integration of Australia's research and project capacity with international efforts, particularly with regard to vaccine and microbicide development and trialling
- ◆ development of a position on funding of and access to affordable HIV therapy in developing countries
- ◆ development within the Asia-Pacific region of inter-country agreements on treatment and prevention programs for STIs.

Recommendations from the Review of the National HIV/AIDS Strategy

The HIV/AIDS Review Panel recommends as follows:

31. That a major new national education program on prevention be developed with the states and territories and key stakeholders—for the term of a fifth National HIV/AIDS Strategy and beyond—to decrease rates of unprotected anal intercourse, related STIs (gonorrhoea and chlamydia) and HIV transmission among men who have sex with men. This program should include, among other things:
 - ◆ development and enforcement of agreed codes of conduct within all 'sex on premises' venues—including prevention education, condom distribution, promotion of HIV and STI counselling and testing, and promotion of non-occupational post-exposure prophylaxis for men
 - ◆ development of new communication and community-based programs to reach young gay men, men who have sex with men but are not attached to the gay community, and gay men living in rural and remote areas
 - ◆ development of a national annual sexual health check-up program for men who have sex with men, along with continuing public campaigns to increase the availability of and participation in counselling and testing
 - ◆ review and updating of HIV-testing guidelines.
30. That harm-reduction approaches, in their broadest sense, be strongly supported from the funding and policy level-perspectives. This includes:
 - ◆ needle and syringe programs
 - development of best-practice models for needle and syringe programs—for example, referral systems and local community management systems involving police, traders, residents, pharmacists, local government, non-government organisations and magistrates courts
 - support for expanded hours
 - provision of sterile water
 - workforce development
 - ◆ availability of medical detoxification
 - ◆ a broad range of substitution therapies—methadone, buprenorphine, and so on
 - ◆ availability of abstinence-based therapies
 - ◆ connections to and from the prison systems—see also recommendation 32

- ◆ peer education programs
 - ◆ an education program for decision makers and the general community.
31. That new approaches to harm reduction—such as the use of supervised injecting facilities, syringes with retractable needles, and medically prescribed heroin—be rigorously evaluated.
 34. That, in close collaboration with the states and territories, a national HIV prevention and care program for prisons be developed. This should include:
 - ◆ increased availability and uptake of both substitution-based and abstinence-based treatments for drug users in prisons
 - ◆ strong continuing engagement with prison officers and their unions to develop programs—for example, in-prison needle and syringe exchange programs—that benefit the officers as well as the prisoners.
 33. That culturally and linguistically diverse communities at high risk of HIV transmission be added to the other priority groups in the current Strategy—Aboriginal and Torres Strait Islander peoples, people who inject drugs, people in custodial settings, sex workers, and the male and female partners of these people—and that a national program be developed with the states and territories to reduce transmission in these communities.
 34. That the next-generation national program of epidemiological, behavioural and clinical surveillance be developed. This should include new testing technologies, such as the detuned ELISA test, and indicators such as HIV testing patterns, viral load, unprotected anal intercourse, condoms, and needles and syringes.
 35. That one of the main performance indicators for the National Centre in HIV Epidemiology and Clinical Research be the extent to which the Centre builds surveillance capacity with the states and territories.
 42. That a national workforce-development program be designed and implemented with the states and territories and key stakeholders.
 43. That the Commonwealth revitalise its national leadership role through enhanced funding, policy development, research, overall coordination, support for the partnership, and international assistance.
 38. That the current governance structure be dissolved and that four advisory committees be established—HIV, Hepatitis C, a Legal Committee, and an Indigenous Australians' Sexual Health Committee—with coordination achieved through a committee of Chairs and Deputy Chairs.
 39. That a Governance Charter be developed to clearly define the respective roles of the different elements of the new governance structures—for example, advisory committees, working groups and government departments.
 40. That the Commonwealth Parliamentary Liaison Group be revitalised and supported and be seen as a very important element of the national response.
 41. That consideration be given to developing a national strategy for STIs, to rekindle interest in working with Australia's young people.
 42. That a framework for continuing evaluation of the National HIV/AIDS Strategy be developed and implemented.

43. That a biennial, comprehensive study to identify, document and track over time the responses to HIV/AIDS at the national, state and territory and local levels be developed and carried out.
44. That resources be specifically dedicated to the establishment of new and continuing capacity to analyse and monitor the economic benefits and costs to government and the community of HIV programs and their components and sub-components.
45. That the National Centres in HIV Research commit increased effort and resources to understanding changing trends in unprotected anal intercourse, gonorrhoea and HIV infection in Victoria and South Australia.
46. That the agenda for the National Centres in HIV Research be set by means of a consultative process at three-year intervals, with provision for rapid responses to emerging problems as they arise.
47. That a cross-sectoral working group—with representation from the Department of Health and Ageing, AusAID, the Department of Foreign Affairs and Trade, and the Department of Immigration and Multicultural and Indigenous Affairs, plus co-opted external experts—be established to expand and coordinate Australia's international role in HIV/AIDS. The working group should report to the HIV Committee of the new governance structure.
48. That the Department of Health and Ageing work with AusAID to develop a mechanism for improving the participation of Australian experts in our international response.
51. That task-focused, time-limited working groups—reporting to the HIV Committee—develop national approaches to complex cross-government questions such as:
 - ◆ income support for people living with HIV/AIDS
 - ◆ access to therapies
 - ◆ models of care for people living with HIV/AIDS, including evaluation of the GP Enhanced Care Pilot Project in New South Wales
 - ◆ mental illness services
 - ◆ supported accommodation and housing for people living with HIV/AIDS
 - ◆ Medicare ineligibility.
52. That a fifth National HIV/AIDS Strategy be developed to further develop and implement the foregoing recommendations. The Strategy should cover the three years from 2004–05 to 2006–07 and should be reviewed in mid-2006.

National Hepatitis C Strategy Review

The Hepatitis C Review Team recommends as follows:

51. That the partnership approach be reaffirmed as essential to an effective national response to hepatitis C and that the non-government and community sector's capacity to respond be enhanced, so that the sector can participate more effectively in the partnership.
52. That new governance structures be developed to support the national response to hepatitis C.

53. That the states and territories review their governance structures for hepatitis C, so that they can develop equitable partnerships and match resources to identified needs.
54. That the National Public Health Partnership be expanded to include local government and non-government and community sector representation.
55. That the Commonwealth Parliamentary Liaison Group be revitalised and recognised as a very important element of the national response to hepatitis C.
56. That equitable, sustained funding be provided to develop and implement an effective response to hepatitis C in Australia at all levels—federal, state and territory, local government, and the non-government and community sector.
64. That the PHOFAs be used to ensure the allocation of a base level of resources and the setting of performance indicators for hepatitis C-related activity at the state and territory level.
65. That—in the light of the findings and recommendations of the November 2001 Anti-Discrimination Board of New South Wales enquiry into hepatitis C related discrimination—the Commonwealth and state and territory governments give priority to redressing hepatitis C-related discrimination in their jurisdictions.
66. That—on the basis of the experience of the New South Wales Hepatitis C Awareness Campaign—the Commonwealth support a national hepatitis C public awareness campaign to increase knowledge of and reduce the stigma associated with hepatitis C infection
67. That the following harm-reduction strategies be strongly supported in a range of settings:
 - ◆ NSPs
 - ◆ medical detoxification
 - ◆ substitution therapies—including methadone and buprenorphine
 - ◆ abstinence-based therapies
 - ◆ peer education programs.Newer initiatives such as supervised injecting facilities, medically prescribed heroin and retractable needle and syringe technology should be rigorously evaluated before they are expanded.
68. That the recommendations of the Australian National Council on Drugs position paper on NSPs be implemented in all jurisdictions.
69. That strategic and investigator-initiated research be recognised as fundamental to Australia's response to hepatitis C and be equitably resourced.
70. That research be commissioned to:
 - ◆ investigate the social and behavioural factors relating to hepatitis C transmission in a range of settings and contexts

- ◆ help develop and guide a broad range of hepatitis C prevention and health-promotion activities at all levels—federal, state and territory, local government, and the non-government and community sector
 - ◆ explore the treatment, care and support needs of people living with hepatitis C
 - ◆ investigate the reasons for the low uptake of treatments in Australia
 - ◆ determine the future hepatitis C treatments load relative to the burden of disease
 - ◆ investigate the economic impact of hepatitis C infection in Australia, to account for any changes in costs associated with new treatments
 - ◆ develop and evaluate models of care for hepatitis C in the context of a systematic focus on health services.
64. That the hepatitis C research priorities of ANCAHRD be reviewed and that, if necessary, a new set of priorities be established to direct funding.
65. That the Clinical Trials and Research Committee be abolished and that hepatitis C research be incorporated in the Hepatitis C Committee's brief.
66. That the Commonwealth and the states and territories renew their commitment to hepatitis C surveillance.
67. That the Commonwealth continue its support for the hepatitis C-related surveillance activities of the National Centre in HIV Epidemiology and Clinical Research.
68. That the Communicable Diseases Network Australia:
- ◆ conduct an evaluation of the Australian Hepatitis C Surveillance Strategy as a matter of priority, noting the drawbacks of a surveillance system based on prevalence data and the difficulty of obtaining accurate data on hepatitis C incidence
 - ◆ provide to the existing Hepatitis C Committee, and its successor under a second National Hepatitis C Strategy, an annual report on the implementation of the Australian Hepatitis C Surveillance Strategy.
69. That the annual NSP survey be expanded to include adults and juveniles in custodial settings.
70. That the Commonwealth lead a process, involving all key stakeholders, to review and create opportunities for more strategic and longer term links between the key national strategies referred to in Section 3.5 of the National Hepatitis C Strategy 1999–2000 to 2003–04.
72. That there be greater emphasis on 'front-end' processes to guide the development of hepatitis C strategies, policies and research agendas, including requirements for appropriate engagement of affected communities, collaborative planning processes, and the use of Indigenous advisory and reference structures.

72. That the capacity of all health services be enhanced so that they can address hepatitis C prevention, education, treatment, care and support for Aboriginal and Torres Strait Islander peoples.
73. That culturally appropriate strategies and resources to prevent hepatitis C infection and its consequences be developed with and for Aboriginal and Torres Strait Islander peoples, through the state- and territory-based Aboriginal Health Partnerships and the Aboriginal community-controlled health sector.
74. That culturally appropriate strategies and resources to prevent hepatitis C infection and its consequences be developed with and for people from culturally and linguistically diverse backgrounds.
75. That awareness of the availability and efficacy of hepatitis C treatments be increased by targeted information provision through primary care physicians, specialist liver clinics and NSPs.
76. That a range of models of care for different settings—custodial, rural, and so on—be developed, implemented and evaluated.
77. That equitable funding be provided to develop models of comprehensive primary health care for communities bearing a high disease burden.
78. That an audit of actual treatment response rates become a standard reporting requirement for the states and territories under the Highly Specialised Drugs Program (S100).
79. That a national hepatitis C workforce program be developed in consultation with all key stakeholders. Affected communities should be engaged in the design and delivery of this programs.
80. That people with hepatitis C or at risk of infection and living in rural, regional and remote areas of Australia have equitable access to hepatitis C-related education and prevention interventions, appropriate health care services that ensure a continuum of care, and innovative models of care.
81. That the lessons learnt from the application of harm-reduction strategies in custodial settings in other countries be explored for implementation in Australia.
82. That custodial staff be provided with training in relation to hepatitis C, in the context of occupational health and safety.
83. That a national policy on the provision of pharmacotherapies for illicit drug dependence in custodial settings be developed for all jurisdictions.
84. That broad support be given to initiatives designed to divert people who use illicit drugs away from incarceration and into non-custodial alternatives.
85. That nationally consistent standards for hepatitis C education and prevention be implemented in custodial settings.

86. That—in close consultation with the people affected by hepatitis C, the community sector, the medical, health care, research and scientific communities, and all levels of government—the Commonwealth Department of Health and Ageing develop a second National Hepatitis C Strategy for the period 2004 to 2009, to further develop and implement the recommendations of this Review.
87. That a second National Hepatitis C Strategy:
- ◆ be framed in the context of communicable diseases but take a settings-based approach to health promotion
 - ◆ be supported by dedicated funding, a detailed implementation plan with performance indicators, strong Commonwealth leadership, and new governance structures, including
 - establishment of new, separate Committees for Hepatitis C, HIV and Indigenous Australians' Sexual Health, with a strong focus on implementation of the respective Strategies through setting their own work plans and incorporation of research and health promotion in their agendas. The new Hepatitis C Committee would comprise people with expertise in legislative and regulatory reform, health promotion, illicit drugs, disease prevention, the non-government and community sector and affected communities (including representatives from relevant peak bodies), public health, treatments (including specialist clinical services, general practice and allied health professions), Indigenous Australians' health, research, workforce development, and custodial settings
 - establishment, by the new Hepatitis C Committee, of ad hoc working groups to deal with specific matters
 - establishment of a new Ministerial Advisory Committee for Hepatitis C, HIV and Sexual Health, comprising the chairs of the three new Committees and one overarching chairperson. This Committee would have a primary role in advocacy and securing sufficient resources to enable effective implementation of the Strategies and would be responsible for equity and collation of information, with minimal oversight of the work of the three Committees
 - the new Ministerial Advisory Committee to forge strong links with national governance structures for illicit drugs
 - ◆ reaffirm the six essential components of Australia's response to hepatitis C—developing partnerships and involving affected communities, access and equity, harm reduction, health promotion, research and surveillance, and linked strategies and infrastructures
 - ◆ be supported by appropriate legislative and regulatory frameworks, including drug law reform and anti-discrimination, which are necessary because of the magnitude of the epidemic
 - ◆ be supported by evidence-based strategies developed in all jurisdictions

- ◆ take account of the changes in diagnostics, treatment and care, and workforce development that have occurred during the term of the first Strategy
 - ◆ designate clinical outcome indicators for hepatitis C
 - ◆ be monitored and evaluated in all jurisdictions
 - ◆ be subject to an independent, external mid-term review.
88. That monitoring the impact of hepatitis C in the Asia–Pacific region and international assistance and cooperation in respect of hepatitis C *not* be a primary consideration for a second National Hepatitis C Strategy.

2002 Review of Strategic HIV/AIDS, Hepatitis C and Indigenous Sexual Health Research and the National and Collaborating Centres in HIV Research

The Strategy Research Review Team recommends as follows:

89. That the outgoing Director of the National Centre in HIV Virology Research be congratulated for the Centre's excellent work in carrying out important, internationally recognised research that is of very high quality and significance.
90. That the National Centre in HIV Virology Research, under the leadership of a Director, develop a strategic plan for the duration of its current funding cycle. This plan should guide the Centre's progress towards obtaining competitive funding; it should also include the important core research work (research that is highly strategic but may not necessarily be innovative). The strategic planning process should involve all stakeholders, including the HIV/AIDS advisory structure and the Department of Health and Ageing.
91. That scientists in the National Centre in HIV Virology Research review areas of commonality between the hepatitis C and human immunodeficiency viruses and their immunovirology and strengthen links with virologists working on hepatitis C in Australia and elsewhere. Where appropriate, funding could be sought for this research through the competitive grant processes.
92. That the National Centre in HIV Social Research and the Australian Research Centre in Sex, Health and Society be congratulated for their high-quality, internationally recognised work in HIV social research.
93. That—where it is possible, feasible and appropriate—the National Centre in HIV Social Research and the Australian Research Centre in Sex, Health and Society engage with National Centres on Drug Research when doing work relating to injecting drug users.
94. That the Director and Deputy Director of the National Centre in HIV Epidemiology and Clinical Research be congratulated for their outstanding achievements in HIV epidemiology, surveillance and clinical research.
95. That block funding for the National Centre in HIV Virology Research cease at the end of December 2004.

96. That a process be developed and funds be identified for purchasing ‘core research’ in HIV virology and immunovirology.
97. That a process be developed and funds be identified for purchasing a networking and communication function for research in HIV virology and immunovirology and that this function be placed with one of the laboratories or institutions that has received funding for the core research.
98. That there be no restrictions on National Centre in HIV Virology Research researchers applying for NHMRC or Australian Research Council funding as a result of receiving funding for core research or the networking function.
99. That the researchers currently involved in the National Centre in HIV Virology Research be encouraged to apply jointly for funding for the ‘core research’ and networking function.
100. That the researchers currently involved in the National Centre in HIV Virology Research be supported and encouraged to develop expertise in obtaining competitive funding to pursue innovative investigator-initiated research.
101. That the Population Health Division of the Department of Health and Ageing continue to fund the National Centre in HIV Social Research and the Australian Research Centre in Sex, Health and Society for at least the next five years—initially, through a new five-year funding agreement.
102. That a new process for determining the research priorities of the National Centre in HIV Social Research and the Australian Research Centre in Sex, Health and Society, drawing in other researchers and stakeholders, be developed.
103. That both the National Centre in HIV Social Research and the Australian Research Centre in Sex, Health and Society be encouraged to nurture social research outside Sydney and Melbourne through collaborative projects and mentoring. This would include developing HIV social research expertise outside the two major Centres.
104. That both the National Centre in HIV Social Research and the Australian Research Centre in Sex, Health and Society—and the former in particular—pursue their host universities for increased support, in recognition of the kudos they bring to their hosts.
105. That the processes of funding and administering the funding of the National Centre in HIV Social Research and the Australian Research Centre in Sex, Health and Society remain with the Population Health Division of the Department of Health and Ageing. Should the Department choose to transfer this function to another body, however, the conditions specified in recommendations 101 to 104, and any others that may be identified by the advisory structure in consultation with the two Centres, should still be met.
106. That the Population Health Division of the Department of Health and Ageing continue to fund the National Centre in HIV Epidemiology and Clinical Research for at least the next five years—initially, through a new five-year funding agreement.

107. That the National Centre in HIV Epidemiology and Clinical Research pursue its host university for increased support, in recognition of the kudos it brings to its host.
108. That the National Centre in HIV Epidemiology and Clinical Research explore ways of expanding the reach of its expertise—particularly in communicable diseases surveillance and in conducting clinical trials in the primary care setting—into other areas of concern to the Population Health Division.
109. That the Population Health Division continue to provide the National Centre in HIV Epidemiology and Clinical Research with additional funds for hepatitis C surveillance and that these funds be rolled into the Centre's core funding.
110. That the processes of funding and administering the funding of the National Centre in HIV Epidemiology and Clinical Research remain with the Population Health Division. Should the Department choose to transfer this function to another body, however, the conditions specified in recommendations 106 to 109, and any others that may be identified by the advisory structure in consultation with the Centre, should still be met.
111. That strategic hepatitis C research be acknowledged as central to the Australian response to hepatitis C. Processes should be set up and resources allocated accordingly.
112. That the Population Health Division explore with the NHMRC and the Australian Research Council ways of funding a program of hepatitis C research over a long-term time frame, such as through Partnership funding.
113. That the Department of Health and Ageing explore ways in which research into the sexual health of Indigenous Australians, as well as hepatitis C and HIV in this population, can be supported and funded through appropriate mechanisms, integrating this with the current reform agenda in Aboriginal research that is being developed nationally.
114. That the Population Health Division resume dialogue with AusAID with a view to obtaining funding support for Australian researchers to work in HIV-related research in the Asia-Pacific region.
115. That the Population Health Division explore ways of accessing research expertise to assist with the management of a research program, including developing priorities for research and translating the research results into policy and practice.
116. That the Clinical Trials and Research Committee of ANCAHRD be abolished and a revised advisory structure be formed, with HIV/AIDS, hepatitis C and Indigenous sexual health committees having a mixture of policy and research expertise. The advisory structure's overarching body should have only minimal influence on the work of these committees.
117. That there be a triennial time frame for setting research priorities in the areas of HIV/AIDS, hepatitis C and the sexual health of Indigenous Australians. All the relevant stakeholders should be involved in deciding the priorities, and the process should include a review of research undertaken to that time.

118. That the research priorities determined for each three-year period be communicated to the NHMRC and the Australian Research Council, with a view to influencing funding decisions. The priorities should be used to assess the significance of competitive grant applications in the areas of HIV/AIDS, hepatitis C and Indigenous Australians' sexual health.
119. That, wherever possible, competitive funding sources be used for funding priority research and that core funding provided to the Centres be used for research that is of the highest priority and/or would be unlikely to be funded through competitive processes.
120. That the NHMRC, the advisory structure replacing the Clinical Trials and Research Committee, and the Population Health Division of the Department review the practice of restricting competitive grant applications by the Centres, with a view to removing the restrictions in the light of the processes recommended here.
121. That the role of the Centres' Scientific Advisory Committees be strengthened and broadened to include overseeing, monitoring and communication tasks. The name 'Scientific Advisory Committee' might need to be changed to reflect this.

2002 Quinquennial Review of the National Centre in HIV Virology Research

The following is recommended:

122. That the National Centre in HIV Virology Research be sustained beyond 2003, with a nodal structure, as part of a strategic approach to the international HIV/AIDS epidemic.
123. That, following the resignation of the current Director, effective 31 December 2002, an interim Director be appointed for the transition period, who will be asked to maintain the scientific excellence at the Centre and to support the scientific staff, in collaboration with the incoming Director of the Burnet Institute.
124. That the interim Director be chosen from among the current principal investigators of the Centre.
125. That new applications for core support of the Centre be opened up for competitive bidding within the wider HIV virology and immunology community.
126. That the appointment of a new Director be incorporated in the new application process.
127. That responsibility for hepatitis C strategy research remain outside the terms of reference of the National Centre in HIV Virology Research and that an alternative mechanism be established to earmark funding for hepatitis C virology research.
128. That the HIV virology core research by the Centre be clearly defined, as outlined in this report, and that contracts for provision of this service very clearly describe the work required and the reporting structure.
129. That the role of the Scientific Advisory Committee be strengthened to oversee and monitor both strategic planning and scientific standards, and to provide regular written reports to ANCAHRD.

130. That services provided by the Centre, as outlined in this report, be incorporated in an annual work plan and include support for overseas collaborations and immunovirology monitoring for clinical studies of the molecular characterisation of HIV.
131. That links between this Centre, clinical groups and the National Centre in HIV Epidemiology and Clinical Research be fostered.
132. That Dr Stephen Kent's formal linkage to the Centre be a priority for the future.
133. That an administrative mechanism be established that allows scientists providing core virology services 'under contract' access to peer-reviewed grant support, including from the NHMRC.
134. That administrative arrangements for the Centre beyond 2003 be clearly defined and transparent from the outset.

2002 Quinquennial Review of the National Centre in HIV Social Research and the Australian Research Centre in Sex, Health and Society

The following is recommended:

145. The Panel considers that the future social research program at both the National Centre in HIV Social Research and the Australian Research Centre in Sex, Health and Society would benefit from more formalised planning in a number of areas:
 - in relation to funding sources and conditions, the identification of priority fields for research and the need to achieve a balance between research in HIV/AIDS, hepatitis C and sexual health in both the Indigenous and general populations
 - clearer demarcation of research effort between the two Centres in relation to their respective strategic strengths and track records in the production of high-quality research
 - processes for undertaking international work in a coordinated fashion.
146. That the National Centre in HIV Social Research and Australian Research Centre in Sex, Health and Society continue to build on their respective research strengths, both substantively and methodologically, in a complementary and collaborative fashion.
147. That the National Centre in HIV Social Research and Australian Research Centre in Sex, Health and Society encourage exploration of joint activities such as publications, conferences and seminars, senior researcher training and development, new forms of community liaison, and induction for new research staff.
148. That the National Centre in HIV Social Research and Australian Research Centre in Sex, Health and Society encourage fuller involvement of their senior researchers in joint planning processes.
149. That the National Centre in HIV Social Research and Australian Research Centre in Sex, Health and Society prepare explicit statements dealing with joint agreements between the two Centres and ensure the dissemination of these statements.

150. That, with a view to promoting research-career development, the National Centre in HIV Social Research and Australian Research Centre in Sex, Health and Society encourage the introduction of a rolling program of career and professional development for staff at all levels in both organisations. Such a program could include emphasis on the provision of support and mentoring for publication and the development of a staff exchange program within and between the various components of the HIV/AIDS social research programs, at these Centres and elsewhere.
151. That existing mechanisms for accountability and scientific direction, including the Scientific Advisory Committees, be retained. Efforts should be made to encourage joint planning with respect to the development of research programs, inclusive of the respective Scientific Advisory Committees of both the Centres.
152. That the National Centre in HIV Social Research and Australian Research Centre in Sex, Health and Society develop systematic policies for striking the best balance in relation to publication of research results—including consideration of formalising systems for encouragement and support for publishing and setting annual targets for staff at different levels in each Centre.
153. That the host institutions for both Centres give consideration to the creation of a greater number of stable research positions.
154. The Panel recognises that liaison with government is a two-way process, but pursuit of a clearer and more coherent relationship with AusAID would be a distinct advantage to both Centres. Beyond this, and to further augment the two Centres' capacity to work outside Australia, development of stronger relationships with UN agencies should become a priority.

2002 Quinquennial Review of the National Centre in HIV Epidemiology and Clinical Research

The following is recommended:

145. That a third level of management in the Centre be introduced.
146. That the Scientific Advisory Committee be streamlined, so that it provides the scientific guidance the Centre needs and that alternative mechanisms be explored for expanding the contribution of collaborators, stakeholders and other experts to the Centre's work.
147. That in the next five years the Centre receive core funding that takes into account annual inflationary costs and the Centre's expanding surveillance functions (see also recommendation 151).
148. That the Centre identify or develop national expertise in anti-retroviral pharmacology to support this area of research.
149. That the Centre conduct trials in hepatitis C-infected injecting drug users in collaboration with providers of their long-term care.
150. That the Centre explore, through further national and international collaboration, use of its unique repository of specimens on HIV-infected patients.

151. That the small amount of additional core funding for hepatitis C and B surveillance be extended for five years, taking into account annual inflationary costs. Expansion into the area of STIs, with improvements in the quality of data, will require additional core funding.
152. That support be sought from AusAID for expansion of the program in the Asia–Pacific region and preparation for the vaccine work. It may be necessary for the Centre to work with other groups in Australia who have a longer history of working experience in developing countries.
153. That the Centre continue to expand its work on Indigenous Australians' health, including hepatitis C, through its work with the Indigenous Australians' Sexual Health Committee and in collaboration with other research and health service provider organisations with expertise in Indigenous health.
154. That discussions begin between the Centre and the University of New South Wales to redefine their relationship, with input from other appropriate authorities. These discussions should take into account the long-term vision for the Centre.
155. That the Centre consider changing its name in the light of its current and future activities.